

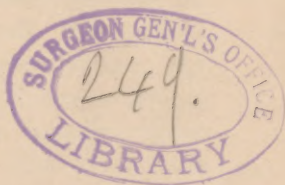
Goodell (Wm.)

A YEAR'S WORK  
IN  
OVARIOTOMY.

BY

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## A YEAR'S WORK IN OVARIOTOMY.

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DURING the past year I have had twenty-five cases of completed ovariectomy, with six deaths. In not a single instance have I declined to operate; for I have given every woman her chance; but I had two cases which I did not complete. One was a patient of Dr. Charles A. Currie, of Germantown. The cyst contained pus, and communicated with the bladder by a very small opening. On January 24th, after making an exploratory incision, and finding that the cyst was adherent at every point, I did not attempt its removal; but I simply emptied it and put in a drainage-tube. The recovery was slow, but without a bad symptom; and the woman left the hospital in about two months. The other case was a patient of Dr. Emil Fischer. When I was called in, she had had septic fever for six weeks, and I found the cyst tympanitic at every point. She was bed-ridden; her temperature was  $102.8^{\circ}$ , and her pulse 140. She also had a bed-sore, night-sweats, a red-raw tongue, and incessant vomiting. Notwithstanding her desperately low condition, I

had her removed to my private hospital, and decided to give her a chance—hoping against hope that there might not be any other complications. On February 21st, with the help of Drs. Emil Fischer, B. F. Baer, T. V. Crandell, and W. L. Taylor, I began the operation. The cyst was universally adherent, and as soon as I began to enucleate it, I saw that my patient would die on the table. So I contented myself with opening the cyst, cleansing it out, and putting a glass drainage-tube in. The contents of the cyst were fairly rotten, and the puff of fetid gas which escaped from the incision was overpowering. The relief, however, was too late, and the lady died fifteen hours later.

I had also in my private hospital a successful case of nephrectomy; the first operation of the kind ever performed in Philadelphia. The patient was a lady from Salt Lake City, brought to me by Dr. J. F. Bird, of Philadelphia. I at first mistook the cyst of the kidney for one of the ovary, but was soon undeceived. The operation was not an easy one, for I had to strip off the investing coat of the peritoneum, to which the intestines were adherent. On account of a very severe bronchitis and an aphthous mouth and throat, the convalescence was slow; but the lady ultimately got well. This aphthous condition of the mouth and fauces was a very remarkable one. I have seen nothing like it, and I cannot help thinking that the additional work

thrown on the remaining kidney must have had something to do with it.

In the following table of twenty-five cases a very unusually large number of double ovariectomies will be noted. There are twelve of them, with three deaths. Of these fatal cases, one, a girl aged 17, died in my private hospital, from acute peritonitis. The other was also a young girl, aged 16, who was operated on in a private-room of the Hospital of the University of Pennsylvania, and died from septicæmia on the ninth day. The third was operated on at home, and died either from shock or from œdema of the lungs. She was in a very feeble condition, and the operation, from pelvic and parietal adhesions, was difficult and tedious. The ether in this case acted badly; the patient becoming cyanosed, and showing afterwards bronchial irritation. I did not see her after the operation. The cysts in these two girls were small, and without serious adhesions. I was greatly disappointed at the result.

From this experience, I am disposed to think it better in such cases to wait until the tumor has developed, and by pressure has so altered the character of the peritoneum as to lessen its vulnerability.

In all these cases of double ovariectomy, the second ovary was removed because, in every instance, it showed evidences of cystic degeneration. But, as my experience ripens, I feel more and more inclined to extirpate both ovaries in certain conditions. For

instance, in future, I shall remove both ovaries whenever the womb contains a fibroid tumor. By so doing, the growth of the fibroid will be checked. Again, whenever the woman has passed the climacteric, I deem it good policy to remove the second ovary, however healthy it may be, in order to take away the chance of its future degeneration.

With regard to the three other fatal cases, a word is needed. Case 71 was in every sense of the word a forlorn case, and operated on from a sheer sense of duty. She was thirty-nine years old, and had borne two children. Ten years ago the tumor was first discovered, but it remained quiescent until two years ago, when it began to grow rapidly, and she came on from Windsor, Vermont, with very indefinite ideas of having something done for it by internal medication. I first saw her on March 27th, and found her bed-ridden with diarrhœa, rectal tenesmus, high temperature, rapid pulse, and night-sweats—and I diagnosticated a suppurating cyst. As she was unwilling to be operated on, even to be tapped, I put her in charge of Dr. T. V. Crandall, who did all in his power to control these symptoms and get up her strength. She, however, became worse; delirium set in; her pulse ranged from 120 to 140 beats; her temperature from  $101.5^{\circ}$  to  $103^{\circ}$ . As she plainly had but a few days to live, I aspirated on April 7th, emptying four cysts from two different punctures. The stench from the putrid fluid was abominable. This operation gave her

some relief for a few days, but she soon became worse than before. So, on April 15th, as a forlorn hope, I decided to remove the cyst at her boarding house, as she was too ill to be removed to the hospital. Drs. B. F. Baer and T. V. Crandall, and my son aided me in the operation; and it was witnessed by Dr. J. H. Rogers, of Sag Harbor, N. Y., and Drs. J. V. Shoemaker, W. Cruice, Vanderbeck, Milliken, and Schwenck. The tumor was a polycyst of the left ovary, with also many exogenous, or outside cysts, each one containing putrid matter. The cyst was adherent at every point up to the pedicle itself, which was short but slender, was much thickened, and glued wholly to the tumor. In breaking up the adhesions in each flank, an abscess outside of the tumor was torn open, and the contents escaped into the peritoneal cavity. Some of the outside cysts also burst and emptied themselves into the same cavity, giving out a sickening stench. The reflected fold of the peritoneum, together with the bladder, was carried up on the cyst-wall as high as the navel, and needed very careful dissection. The right ovary could not be found. Several times during the operation the woman seemed about to die on the table, but she was resuscitated by subcutaneous injections of ether and brandy. She subsequently rallied enough to converse with her friends, but she died about midnight from shock. Altogether, this was the most formidable operation that I have yet performed, and it

is a question in my mind whether, under the circumstances, I ought to have undertaken it; but, knowing that it was her only chance, I felt it my duty to give it to her. Case 79 died comatose, in about forty hours after the operation, which was performed at the Hospital of the University. There were no complications other than the long incision needed for the extraction of a large multilocular tumor, too solid to be reduced in size. There were from the first, coma and suppression of urine. At the autopsy the liver was found to be fatty, the kidneys greatly contracted, and the spleen hypertrophied and breaking down. Her advanced age and the carbolated spray had probably something to do with the unfortunate result. The death of Case 83 remains yet a mystery to me. The operation was performed at the hospital, and was unusually easy. The tumor consisted of a thick-walled, partly solid multilocular cyst of the left ovary, and was nourished more by the omentum, to which it was attached, than by a very slender and long pedicle. She did extremely well for six days; then acute mania set in, from which she died twenty-four hours later. The autopsy revealed no cause whatever for this unexpected death, and I am disposed to attribute it to embolism. She had multiple uterine fibroids, and one of them, as large as an apple and pedunculated, I removed, but I do not think this had anything to do with the result.

A few words about Case 70 are needed. At

the time of the operation she was much emaciated ; very feeble, and greatly distended by eighty pounds of fluid. The sac had hepatic, omental, intestinal, pelvic, and parietal adhesions, and she narrowly escaped dying on the table. For several days she lay in a critical condition ; then she slowly began to mend. She was fairly convalescent when she became homesick, and on the eighteenth day after the operation insisted upon being taken to her home in Camden, New Jersey. A year later I learned that she died from "vomiting" fourteen days after her removal. She was a homœopath, and one of her reasons for going home was that she objected to our medicines.

The results of my cases are not as good as those of British ovariologists ; but these gentlemen do not publish their uncompleted operations, nor the cases on which they decline to operate. Without these data, no just estimate can be made of individual success. My statistics, however, compare very favorably with those of the Vienna General Hospital for 1881. During that year "ovariotomy was performed sixty-four times, with thirty-eight recoveries, twenty-five deaths, and one woman discharged with marasmus."<sup>1</sup>

The chief lessons which I have learned from my experience during the last year, are : First, to administer ether largely diluted with atmospheric air.

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<sup>1</sup> MEDICAL NEWS, Dec. 30, 1882, p. 745.

Hitherto, I have, in common with most American surgeons, given this anæsthetic by a closed cone, in such a way that the patient breathed her own air over and over again. I am now disposed to think that this is a very unsafe mode, and that to it is due, in a large measure, the alarming prostration of the patient while undergoing the operation. For instance, among the twenty-five cases of last year, Cases 70, 71, and 82, presented such profound symptoms of shock, that the operation had to be suspended until hypodermic injections of brandy and of ether were made, and some degree of reaction had set in. In Cases 70 and 71, it was indeed with great difficulty that the women were kept from dying on the table; while Case 85 clearly died from œdema of the lungs. Now, I do not find such alarming symptoms referred to in any reports of cases by British operators. I am therefore forced to the conclusion, that either under the strain of rivalry they do not operate in very desperate cases, or their mode of administering anæsthetics is a safer one than ours. Fully impressed with this idea, I have lately been using Dr. Allis's improved inhaler, and have thus far found it to act promptly, safely, and economically.

My second lesson is not to include the recti muscles in the sutures which close the abdominal wound. In most cases of ovarian tumor, and especially in those in which the cysts are large, the recti muscles are so widely separated from one another,

that they barely come into view, and are not likely to be included in the sutures. But in cases of small cysts, and especially of öophorectomy, the *linea alba*, being then a mere line, cannot always be closely followed by the knife, which is likely to go astray into the sheath of one of these muscles. To get back to the *linea alba* needs careful dissection, and into the more or less ragged wound thus made, the bellies of these muscles pout. The temptation is so strong to include them in the sutures, that I have hitherto done so. But, finding that abscesses are likely to form in the track of these sutures, I now exclude these muscles.

Total Number, . . .	Name and Residence of Previous Medical Attendant.	Age, . . . . .	Condition, . . . .	No. of Children, .	Previous Tappings.	Date of Operation.	Place of Operation.	Adhesions, . . . .	Ovary Diseased, .	Size and Nature of Tumor, . . . . .	Length of Incision.	Drainage, . . . . .	Result, . . . . .	REMARKS.
61	Dr. R. P. Harris, Philadelphia.	50 M	1	1	Jan. 10.	Home.	Omental.	L	20 lbs.	Short.	None.	Recovery.	During the removal of cyst, it burst, and some of the contents escaped into abdominal cavity.	
62	Dr. Robert Burns, Frankford, Pa.	56 S	1	1	Jan. 21.	"	Omental and intestinal.	L 40	"	Long.	"	"	"	Semi-solid multilocu- lar cyst surrounding de- scending colon, to which it was attached.
63	Dr. M. M. Lewis, Alexandria, Va.	36 M			Jan. 28.	Private Hosp <sup>l</sup>	Broad liga- ment and pelvic.	L 3	"	"	"	"	"	A small cyst removed by enucleation from broad ligament. A dif- ficult operation.
64	Dr. H. H. Muthersbach, Beech Creek, Pa.	31 M			Feb. 10.	Univers. Hosp <sup>l</sup> .	Omental and parietal.	R 112 L	"	Short.	"	"	"	Woman weighed 72 pounds after the opera- tion; cyst, 16 pounds; fluid, 96 pounds.

65	Dr. T. J. Varrow, Philadelphia.	65 M 4	Feb 14.	Home.	Parietal and broad liga- ment.	L 10 "	"	"	A tumor of omentum, probably malignant, was also found, but could not be removed.
66	Dr. H. W. Newcomet, Philadelphia.	M	March 1.	Univers. Hosp'l.	None.	L 10 "	"	"	Tumor consisted of a cluster of large cysts, containing a clear fluid.
67	Dr. T. D. Dunn, West Chester, Pa.	27 S	March 1.	"	"	L 20 "	"	"	Oligo-cyst, with clear, limpid fluid.
68	Dr. F. B. Kellar, Pottstown, Pa.	33 M	Mar. 11.	Home.	"	R L	"	"	Abdomen filled with liquid; no cyst, but a cauliflower-looking pa- pillomatous degenera- tion of right ovary.
69	Dr. G. M. Schillito, Alleghany, Pa.	16 S	Mar. 13.	Univers. Hosp'l.	Pelvic and to br. ligament.	L 15 R	"	Died.	Died on ninth day from septicaemia.
70	Dr. Armstrong, Camden, N. J.	30 M 4	Mar. 23.	"	Universal.	R 80 "	Long. Tube.	Recovery.	Several cysts burst into cavity of abdomen during the operation. Taken home on April 9th, and died on 23d from "vomiting."
71	Dr. W. Goodell, Philadelphia.	39 M 2	April 15.	Home.	"	L 20 "	"	Died from Shock.	Was delirious and in last stages of septicaemia when operated on.

Total Number, . . .	Name and Residence of Previous Medical Attendant.	Age, . . . . .	Condition, . . . . .	No. of Children, . .	Previous Tappings.	Date of Operation.	Place of Operation.	Adhesions, . . . . .	Ovary Diseased, .	Size and Nature of Tumor, . . . . .	Length of Incision.	Drainage, . . . . .	Result, . . . . .	REMARKS.
72	Dr. C. McCall, Philadelphia.	56	S			May 4.	Univers. Hosp'l.	"	R	25	"	None.	Recovery.	
73	Dr. Shearer, Sinking Spring, Pa.	34	S			May 17.	Private Hosp'l.	None.	R	20	Short.	"	"	
74	Dr. De Schweinitz, Philadelphia.	37	M	3		June 15.	Univers. Hosp'l.	"	R L	20	"	"	"	
75	Dr. N. F. Ehrenfeld, Indiana, Pa.	46	W	2	5	June 15.	"	Parietal.	R	70	"	"	"	
76	Dr. D. Miller, Huntingdon, Pa	32	M			June 28.	"	Omental.	R L	65	"	"	"	
77	Dr. G. R. Robbins, Hamilton Sq., N. J.	44	W	2		Sept. 6.	Private Hosp'l.	None.	L R	20	"	"	"	
78	Dr. B. F. Baer, Philadelphia.	22	S		2	Sept. 19.	Univers Hosp'l	"	L R	10	"	"	"	

		65 W	1	Oct. 5.	Univers. Hosp'l.	None.	R	25 lbs.	Long.	None.	Died.	Died from uremia, kidneys being greatly diseased.
79	Dr. T. B. Hayes, Belleville, Pa.											
80	Dr. J. W. Anawalt, Greensburg, Pa.	28 M		Oct. 21.	Private Hosp'l.	Uterine and pelvic.	R L	10 "	Short.	"	Recovery.	Right ovary without pedicle, and adherent to womb; left ovary em- bedded in broad liga- ment.
81	Dr. C. M. Gandy, Ocean View, N. J.	42 M	3	Oct. 22.	Home.	None.	L R	15 "	"	"	"	
82	Dr. W. Goodell, Philadelphia	51 M	6	Nov. 13.	Private Hosp'l.	Omental, pel- vic, uterine.	L R	40 "	Long.	"	"	Neither ovary had a pedicle, and each was so adherent to womb that uterine tissue was ligated.
83	Dr. C. W. Gerry, Trenton, N. J.	43 S		Nov. 14.	Univers. Hosp'l.	Omental.	L	30 "	"	"	Died.	A pedunculated fibroid also removed. Patient died on eighth day from acute mania.
84	Dr. L. P. Morawetz, Baltimore, Md.	17 S		Nov. 19.	Private Hosp'l.	None.	R L	15 "	"	"	"	Died from acute peri- tonitis.
85	Dr. J. Simpson, Philadelphia.	31 M	2	Dec. 24.	Home.	Parietal, omental, and pelvic.	L R	50 "	"	"	"	Was greatly debili- tated, and died from shock.

